

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

19729

Registrar's No.

5994

FILED JUL 15 1944

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Weeks
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Elizabeth Gier

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John Gier 6. (c) Age of husband or wife If alive _____ years
7. Birth date of deceased Aug. 4th 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 10 29 hr. _____ min.

9. Birthplace Hungary
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business Housewife

12. Name John Molitor
13. Birthplace Hungary
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth ?
15. Birthplace Hungary
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Gier

- (b) Address: 1842 S 8th St.

17. (a) Burial (b) Date thereof July 7/44
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation New S.S. Peter & Paul

18. (a) Signature of funeral director Thos. H. & Son

- (b) Address 2006 Gravois Ave.

19. (a) JUL 15 1944 (b) J. F. Bueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No 1842 S. 8th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
year 1944 hour 5 10 P. minute _____ M.

21. I hereby certify that I attended the deceased from May 1944 to July 3 1944
that I last saw him/her alive on July 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Multiple obscurities to liver,
kidney, etc
Causal not known

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(b) Means of injury _____

23. Signature Chas. J. Wade (M. D. or other) _____
Address City Hospital Date signed 7/8

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Said Lee Fournier

Licensed Embalmer No. *4242*

P. O. Address. *2906 Morris*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.